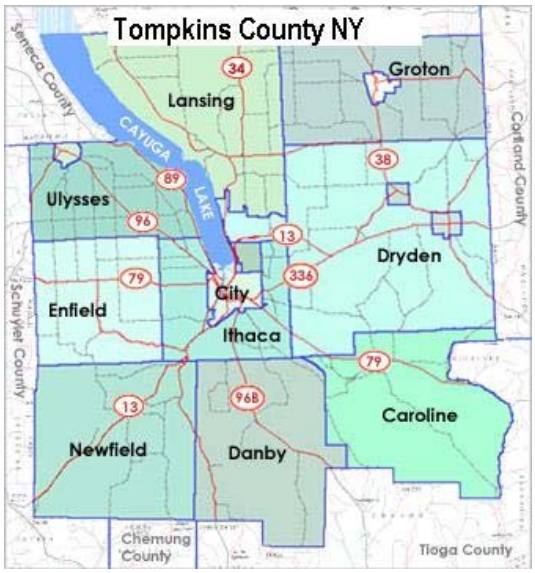
Tompkins County Rural Community Based Care Transition Program

Tompkins County Office for the Aging, Cayuga Medical Center, Visiting Nurse Service of Ithaca and Tompkins County, Hospicare and Palliative Care Services

OUR COLLABORATION

Located in the Finger Lakes region of Central New York., our collaboration includes the Tompkins County Office for the Aging/ NY Connects/ADRC partnering with our area's sole hospital, Cayuga Medical Center. Visiting Nurse Service of Ithaca and Tompkins County and Hospicare and Palliative Care Services provide CTI certified transition coaches. Other key partners include Cayuga Ridge Extended Care (SNF), Beechtree Care Center (SNF), Health Planning Council of Tompkins County, Community Health Foundation of Western & Central NY, IPRO (QIO), and Tompkins County Department of Emergency Response.

OUR COMMUNITY



OUR TARGET POPULATION

Based on readmission data from Cayuga Medical Center, our intervention includes Medicare fee-for-service beneficiaries with the following primary or secondary diagnoses:

- Congestive heart failure
- Chronic obstructive pulmonary disease
- Pneumonia
- Diabetes
- Multiple readmissions/ED/OBV visits for the same condition over the past 6 months

OUR IMPLEMENTATION STRATEGY

An extensive root cause analysis led us to the following problem statement: *Patients and family caregivers are not adequately prepared to manage their conditions during the transition between care settings in the absence of health care professionals, leading to symptom exacerbation, an increased likelihood of crisis, inappropriate health care utilization and readmission to the hospital.*

In order to address these issues, Dr. Coleman's Care Transition Intervention is implemented with eligible patients. The community based CTI coach arranges a home visit within 72 hours following hospital discharge, followed by three follow up phone calls with the patient over a 30 day period. The CTI coach also shares information about NYConnects/ ADRC as a source of additional information about community services.

In addition to CTI, the following programs and services are emphasized:

- Use of Sharing Your Wishes and MOLST forms for advance health care planning
- Use of Next Step in Care resources to assist family caregivers to navigate care transitions

- Connection to evidence-based programming in the community, including the Stanford Chronic Disease Self-Management Program and Powerful Tools for Caregivers
- Teach back method is utilized at the hospital to increase patients' understanding of their illness and care management